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Shield Spectrum PPO Plan 5000

Comprehensive coverage with one of our lowest monthly PPO premiums



Shield Spectrum PPOSM Plan 5000* offers you low-cost protection from major healthcare expenses along with the flexibility to visit the doctors and specialists you want to see. When you receive care from Blue Shield Life PPO preferred providers, your out-of-pocket costs are less.

Advantages of the plan include:

- Preventive care services and generic prescription drugs with a fixed dollar copayment before you meet the annual deductible
- Added protection of \$10,000 in *Critical Condition Protection*SM **
- One of California's largest PPO provider networks, with over 45,000 doctors and more than 350 hospitals
- Copayment maximums to help contain costs

Comprehensive coverage at a reasonable cost

Even if you don't visit the doctor often, you know how important it is to have coverage to help protect yourself from unexpected medical expenses. You also appreciate having the freedom to see the doctor you want, but you don't want to pay a lot for monthly premiums. You should consider the Shield Spectrum PPO Plan 5000.

Additional Services

Blue Shield offers a wide variety of value-added services to help our members make better-informed healthcare decisions and manage their health plan benefits more effectively. The *Lifepath Advisers*SM program offers assistance for professional and personal concerns 24 hours a day by connecting you with a registered nurse, master's level counselor or work-life balance resources. Through our innovative Web site, mylifepath.com, members have 24-hour access to resources such as My Health Plan, to find out about their specific plan benefits and services, Pharmacy to compare the costs of generic versus brand-name drugs and *Lifepath Decision Guide*SM to find out about treatment options for a diagnosed condition.

*Underwritten by Blue Shield of California Life & Health Insurance Company.

** Critical Condition Protection (CCP) is part of the Shield Spectrum PPO Plan 5000. Members who have a first incident of severe heart attack, severe stroke or certain life-threatening cancer become eligible for this benefit. There are restrictions that apply. Payment related to the CCP benefit is not restricted to medical care expenses. Therefore, a portion of your monthly premium payment allocable to the CCP may not be tax deductible. Blue Shield does not provide tax advice and this cannot be considered tax advice. If you have any questions, you should contact your tax advisor.

Visit us at mylifepath.com

Individual and Family Plans

Shield Spectrum PPO Plan 5000

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE POLICY FOR INDIVIDUALS AND FAMILIES SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Shield Spectrum PPO Plan 5000	
This plan is underwritten by Blue Shield of California Life & Health Insurance Company.	
DEDUCTIBLE*	\$5,000 (\$10,000 Family)
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers
COINSURANCE	30% with Preferred Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Includes the plan deductible. Some services do not apply.)	Services with Preferred Providers: \$7,000 (\$14,000 Family) Services with All Providers: \$10,000 (\$20,000 Family)
LIFETIME MAXIMUM	\$6,000,000
CRITICAL CONDITION PROTECTION	\$10,000 per member, per lifetime
* Benefits for covered brand-name drugs are subject to a separate \$500 brand-name drug deductible per person.	

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES		
– Office visits	\$35	50%
PREVENTIVE CARE		
– Annual Routine Physical Exam, Well-baby care office visits, and Gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	\$35	Not Covered
OUTPATIENT SERVICES		
– Non-Emergency services and procedures, Outpatient surgery in hospital	30%	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	30%	50%
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	50%
– Inpatient semiprivate room and board, services and supplies and subacute care	30%	50% ^{2,3}
EMERGENCY HEALTH COVERAGE		
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies and subacute care not resulting in admission	30%/visit	30%/visit
– ER Physician visits	30%	30%

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
AMBULANCE SERVICES (Surface or Air)	30%	30%
PRESCRIPTION DRUG COVERAGE⁴ (outpatient; brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year. Prescription coverage differs for Home Self-Injectibles. Please review the Policy before you purchase the plan.)	At Participating Pharmacies (Up to a 30-day supply)	Mail Service Prescriptions (Up to a 60-day supply)
– Generic formulary drugs	\$10/prescription ²	\$20/prescription ²
– Formulary brand-name drugs	\$35/prescription ²	\$70/prescription ²
– Non-formulary brand-name drugs	\$50 or 50%/prescription (whichever is greater) ²	\$100 or 50%/prescription (whichever is greater) ²
DURABLE MEDICAL EQUIPMENT⁵	30%	50%
	With MESA Participating Providers,¹ you pay	With MESA Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES⁶		
– Inpatient Hospital Facility Services	30%	50% ^{2,3}
– Inpatient Physician Services	30%	50%
– Outpatient visits for severe mental health conditions	\$35	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	30%	Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ⁶		
– Inpatient Hospital Facility Services for medical acute detoxification	30%	50% ^{2,3}
– Inpatient Physician Services for medical acute detoxification	30%	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30%	Not Covered
	With Preferred Providers,¹ you pay	With Non-Preferred Providers,¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%	Not Covered
OTHER		
Pregnancy and Maternity Care		
– Outpatient prenatal and postnatal care	30%	50%
– Delivery and all necessary inpatient hospital services	30%	50% ^{2,3}
Family Planning		
– Consultations, tubal ligation, vasectomy, elective abortion	30%	Not Covered
Rehabilitation Services (up to 12 visits per calendar year combined with speech therapy visits)		
– Physical, occupational, or respiratory therapy	30%	50%
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	50% with all other providers

See following page for footnotes.

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

- 1 Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.
- 2 These copayments do not count toward the copayment/coinsurance maximum and will continue to be charged once it is reached.
- 3 For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to \$250 per day. Members are responsible for all charges that exceed \$250 per day.
- 4 If a member requests a brand-name drug or the physician indicates Dispense As Written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug.
- 5 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- 6 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.

Please Note: This document is not a contract and should only be distributed with a presale disclosure document which explains general plan exclusions and limitations. Both documents should be read together. For actual complete benefit descriptions, terms and conditions and limitations of the health plan, please read the *Policy for Individuals and Families* (Policy). For a complete description of the Shield Spectrum PPO Plan 5000, you can request a copy of the Policy by calling **(800) 431-2809**.